COMMISSIONER OF SECURITIES & INSURANCE

MONICA J. LINDEEN
COMMISSIONER

OFFICE OF THE MONTANA
STATE AUDITOR

Advisory Memorandum

To: **ALL HEALTH INSURANCE INSURERS**

From: **MONICA J. LINDEEN - Commissioner of Securities and Insurance**
Office of the Montana State Auditor [CSI]

Date: **October 18, 2010**

COLLECTION OF RATE DATA FOR ALL PRODUCTS PROVIDING HEALTH INSURANCE COVERAGE

Section 1003 of the Affordable Care Act of 2010, (P.L. 111-148) (ACA), requires the Secretary (Secretary) of Health and Human Services (HHS), in conjunction with the states, to "establish a process for the annual review, beginning with the 2010 plan year … of unreasonable increases in premiums for health insurance coverage." The state of Montana, along with 45 other states, applied for and received a grant from HHS that enables it to collect rating information so that it can fulfill its duties under the ACA. As a condition of receiving that grant, the Commissioner of Securities and Insurance (CSI) must "provide the secretary with information about trends in premium increases in health insurance coverage in premium rating areas in the State." The information about premium rating trends is also required to enable the CSI and HHS to evaluate rate increases. The purpose of this advisory memorandum is to request health insurance issuers selling, issuing and delivering health insurance products, including products sometimes known as "mini-medical plans," (that are not "excepted benefits" as defined in Mont. Code Ann. § 33-22-140) to Montana residents to submit certain rating information for the following three purposes:

- To enable proper review of rating information so that CSI can fulfill its obligation under the ACA to report "unreasonable rate increases" to the Secretary;
- To report trends in premium increases as required by the Secretary;

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- To review compliance with existing Montana rating law and rating disclosure laws for all health insurance issuers doing business in Montana.

Even though the Secretary has not yet defined "unreasonable rate increase," the states must move forward with collecting rating data for eventual reporting to HHS. All states must report rating information to HHS, regardless of whether or not they received grant money from HHS. In order to determine that some rate increases may be "unreasonable," report on premium rating trends, and establish a baseline going forward, it is necessary to collect information and justifications concerning all rates currently in use in Montana, as well as historical information about past rates, and information concerning proposed rate increases for 2011 for all health insurance issuers currently doing business in Montana.

In anticipation of meeting the requirements imposed on state insurance departments, a working group established by the National Association of Insurance Commissioners (NAIC) has developed a "rate filing disclosure form," and another working group is developing changes to the System for Electronic Rate and Form Filing (SERFF) in order to collect rate data required to be reported to HHS by the ACA and by the terms of the grant award. Both of these groups are working closely with HHS staff on the development of these documents and industry participation has been encouraged throughout that process. Montana will utilize these uniform reporting documents for requesting the information needed. Currently the NAIC forms are in "draft" form, but it is expected that the forms will be finalized at the NAIC meeting the week of October 18. Please check the CSI website for the final documents to be posted sometime after October 25, 2010. The CSI is sending these documents now in order to give companies as much time as possible to collect this information. **These draft documents are attached and outline the data that the CSI is requesting, so that information will not be restated in the advisory memorandum.** The "rate filing disclosure form" has directions and an explanation for each item requested. The "data elements" document contains a "dictionary" of rate data elements that must be reported on SERFF and transmitted by the states to HHS as part of the grant reporting requirements that also fulfill ACA requirements. All of the information outlined in these draft documents must be reported to the CSI on SERFF.

In addition to the rate information that must be collected, analyzed and forwarded to HHS, the CSI will also be reviewing compliance with existing rating laws and rating disclosure laws in Montana, including small employer group rating laws and Mont. Code Ann. § 33-22-243 (premium increases to be distributed proportionally in the individual market). **All small group health insurers must submit a copy of their small group rating manual.** This information will be protected pursuant to the statute as a trade secret. This information will be used to determine compliance with Title 33, Chapter 22, Part 18, and to assist in analyzing small employer group rates.

There are several disclosure requirements concerning rates in Mont. Code Ann. §§ 33-22-244 and 33-22-521, such as "a general description of the factors or case characteristics that the insurer may consider in establishing or changing the premiums and, if applicable in determining the insurability of the applicant," and "a general description of the trend of premium increases or decreases for comparable policies issued by the insurer during the preceding 5

years." The CSI will be requiring more detailed descriptions of these items in the outlines of coverage during the form review process and will be checking the information received during the data collection process against the information provided to consumers in the outline of coverage.

In order to facilitate all three purposes stated in paragraph one, **the CSI is also requiring that all health insurance issuers doing business in Montana submit their average premium increases for each policy form in the individual and group health insurance market for the last three years.** In order to establish a necessary baseline, the information requested in the Rate Filing Disclosure Form in sections A, B and C #'s 1 – 5 must be provided for 2008, 2009 and through September 30, 2010. This information will not be submitted on SERFF, but rather must be submitted directly to the CSI by mail or email.

On its website, the CSI will post summaries of proposed rate increases by health insurance issuer and by policy form numbers, as well as summaries of rate increase trends since 2008. Companies will be contacted individually concerning the information that will be posted about each company's rates, so that companies can review the information for accuracy, as well as for any information that might be protected as a trade secret.

The CSI is collecting this information pursuant to its authority to examine and investigate under Mont. Code Ann. § 33-1-314. Thank you for your cooperation in this matter.

The following is a list of information required to be submitted to the CSI by this advisory memorandum:

- **All of the information listed in the Rate Filing Disclosure Form and the rate data elements listed in the SERFF data dictionary (both attached to this memorandum) must be submitted on SERFF.**
- **All small group health insurers must submit a copy of their small group rating manual (submitted by mail or email.)**
- **The average premium increases for each policy form in the individual and group health insurance market for the last three years. This information must include the data elements listed in the Rate Filing Disclosure Form in sections A, B and C-- #'s 1 – 5 and must be provided for the years 2008, 2009 and through September 30, 2010 (submitted by mail or email.)**

The information requested should be submitted to Mari Kindberg, Chief Actuary on SERFF or at mkindberg@mt.gov or 840 Helena Ave., Helena, MT 59601, **no later than November 30, 2010**. Information should be formatted in Excel or Microsoft Word. If sending large amounts of information by mail, please place that information on two duplicate compact discs or DVDs. If sending large amounts of information by email (more than 2 MB), please use a zip file or some other way to compress the information. If you have questions, or if you believe that this advisory memorandum does not apply to your company, please call or email Ms. Kindberg at 406-444-5220.

The following three sections apply to those premium increases that meet the "unreasonable" test under Section 2794 of the Public Health Service Act. Health insurance issuers are required to submit the information required under these three sections and a complete rate filing which includes a justification for the premium increase to the Secretary and the relevant state prior to the implementation of the increase.

Section I - Rate Filing Disclosure Form

A: Issuer Information and Type of Plan

1. Name of the Health Insurance Issuer	
2. NAIC Company Code	
3. Name of State in which the Rate was Filed	
4. Type of Plan (Individual, Small Group, Large Group, or Conversion)	
5. SERFF Tracking Number(s) for Filing	
6. State Tracking Number	
7. Policy Form Number(s)	
8. Plan Name(s)	
9. Product Type (HMO, PPO, etc...)	
10. Brief Description of Deductible, Copayment and Coinsurance	
11. Open or Closed Block of Business	

B: Rate Request

1. Proposed Effective Date	
2. Number of Covered Persons in this State	
3. Number of Covered Persons Under the Plan(s) Nationwide	
4. Proposed Average Rate Increase/Decrease* [show as % and Average Per Member Per Month (PMPM) increase/decrease from one year earlier]	% Increase/decrease from PMPM to PMPM
5. Minimum Rate Increase/Decrease for any Individual* [show as % and Average Per Member Per Month (PMPM)	% Increase/decrease from

increase/decrease from one year earlier]	PMPM to PMPM
6. Maximum Rate Increase/Decrease for any Individual* [show as % and Average Per Member Per Month (PMPM) increase/decrease from one year earlier]	%
	Increase/decrease from PMPM to PMPM

**The average rate does not mean that the premium will increase/decrease by this amount. Premiums are affected by many factors, including ages of the people covered, whether family members are covered and the date the policy renews. The "Minimum/Maximum Rate Increase for any Individual" is to capture the minimum/maximum premium increase for any individual within this block of business.*

C: Components of the Average Rate Increase/Decrease and Basis for Rate Request

Break down the "Proposed Average Rate Increase/Decrease" into the following components of rate changes (in percentage):

1. Medical** Utilization Changes	%
2. Medical** Price Changes	%
3. Medical** Benefit Changes Required by Law	%
4. Medical** Benefit Changes Not Required by Law	%
5. Changes to Administration Costs	%
6. Insufficiency of Prior Rates (continuing losses that need to be covered by additional rate – not a recovery of previous losses, but a projection of continued shortfall from target)	%
7. Other Reasons for the Rate Request	%
8. Provide a Simple Calculation of how the Average Rate Increase/Decrease is derived based on the above components of rate changes	

***Medical includes Prescription Drug*

D: Earned Premiums, Incurred Claims, and Underwriting Gain/Loss Per Member Per Month (PMPM) for the 12-Month Experience Period for the Plans Included in this filing filed with this State and for Nationwide if the Plans are Available in Other States

1. (a). Reported 12-Month Period: From (month/year) to (month/year)
   (b). Member Months:

	This State	Nationwide
2. Earned Premiums Excluding Federal and State Taxes and Licensing or Regulatory Fees	PMPM	PMPM
3. Reimbursement for Clinical Services Provided to Enrollees	PMPM	PMPM

4. Activities That Improve Health Care Quality	PMPM	PMPM
5. Federal and State Taxes and Licensing or Regulatory Fees	PMPM	PMPM
6. Administrative Costs Allocated or Assigned to the Plans Reported in this Filing, Excluding Items 4 and 5 Above and by the Following Categories: a) Total annual compensation of the ten highest paid officers or employees, b) Total annual compensation for staff other than ten highest paid officers or employees, c) Agents and brokers fees and commissions, and d) Other General and Administrative Expenses e) Total = a+b+c+d	PMPM PMPM PMPM PMPM PMPM	PMPM PMPM PMPM PMPM PMPM
7. Underwriting Gain/Loss (Line 2 – (Lines 3 + 4 + 6))	PMPM	PMPM

E: Projected Results of the Proposed Rates

A health insurance premium is made up of items 3 through 7 listed in D. If the requested rate change is implemented, the issuer projects the following changes:

	This State	**Nationwide**
1. Reimbursement for Clinical Services Provided to Enrollees as a Percentage of Premiums:	Will change from % (Section I.D.3 as a percentage of Section I.D.2) to %	Will change from % (Section I.D. 3 as a percentage of Section I.D. 2) to %
2. Activities That Improve Health Care Quality as a Percentage of Premiums:	Will change from % (Section I.D.4 as a percentage of Section I.D. 2) to %	Will change from % (Section I.D. 4 as a percentage of Section I.D. 2) to %
3. Federal and State Taxes and	Will change from %	Will change from %

Licensing or Regulatory Fees as a Percentage of Premiums:	(Section I.D.5 as a percentage of Section I.D. 2) to %	(Section I.D. 5 as a percentage of Section I.D. 2) to %
4. Administrative Costs as a Percentage of Premiums:	Will change from % (Section I.D.6 as a percentage of Section I.D. 2) to %	Will change from % (Section I.D.6 as a percentage of Section I.D.2) to %
5. Underwriting Gain/Loss as a Percentage of Premiums:	Will change from % (Section I.D.7 as a percentage of Section I.D. 2) to %	Will change from % (Section I.D.7 as a percentage of Section I.D. 2) to %

F: List the Annual Average Rate Changes Requested and Implemented in the Past Three Calendar Years

Calendar Year	Requested This State	Implemented This State	Implemented Nationwide
	%	%	%
	%	%	%
	%	%	%

Section II - Summary of the Rate Filing

A: Issuer Information and Type of Plan

Provide the description of the issuer, type of plan, SERFF tracking numbers(s) if applicable, policy form number(s), and plan design.

B: Rate Request

Provide a brief description of the carrier's rate-making methodology, including identification of the data used and the kinds of the assumptions and projections made, and the rating requirements specifically required by this State. If this State's data is not credible, describe how a larger set of data is used and how the credibility factors are applied in order to derive the rate projection. List the average number of covered persons during the experience period for this state and for nationwide, and the average proposed rate change. Provide the description of the calculation for the average rate increase/decrease and the minimum/maximum rate change for any individual, including built-in trend factors, duration factors, age, geography, family size, industry, health status and other rating factors used to calculate the average rate

increase/decrease or the minimum/maximum rate change. Include a detailed description of how the average rate increase/decrease and the minimum/maximum rate change are translated into the increase/decrease per member per month (PMPM). Provide an illustrative example if necessary. List the rating requirements (such as adjusted community rating) and citations of the rating requirements specifically required by this state.

C: Component of the Average Rate Increase and Basis for Rate Request

Provide a detailed description of each component of rate changes listed in C of the Rate Filing Disclosure Form and the calculation of the overall average rate increase/decrease derived from these components. . List benefits changes required by law, and not required by law, including changes to deductible, copayment, coinsurance and essential health benefits defined under Section 1302(b) of the Patient Protection and Affordable Care Act. Provide reasons for the benefits changes not required by law.

D: Earned Premiums, Incurred Claims, and Underwriting Gain Loss Per Member Per Month (PMPM) for the 12-Month Experience Period for the Plans Included in this filing filed with this State and for Nationwide if the Plans are Available in Other States

Provide each item listed in D of the Rate Filing Disclosure Form for the 12-month experience period from this state and nationwide. List and explain in detail all adjustments in earned premiums, such as state assessments, collections or receipts for risk adjustment and risk corridors, and payments of reinsurance. List all activities that improve health care quality.

E: Projected Results of the Proposed Rates

Include detailed calculations of each item listed in E of the Rate Filing Disclosure Form. Provide all justifications of any adjustments used to calculate these projected results.

F: List the Annual Average Rate Changes Requested and Implemented in the Past Three Calendar Years

Show rate changes on an annual basis by calendar year. Provide an explanation of how these calendar-year rate changes were translated from past rate filings.

G: Additional Comments

Provide additional comments from an officer on the reasons for the rate change including the following topics:

1. Whether certain benefits have been reduced or enhanced in order to steer members away from less effective or less cost-effective services,
2. Any efforts toward cost containment and quality improvement, especially those inaugurated since the insurer's last rate filing, and
3. How rate changes can vary depending on rating factors, with examples.

Section III – Documentation and Justification Required for a Rate Filing

Each rate filing must include the following information and documents:

1. A description of the health insurance issuer's rate-making methodology, including a description of the benefit plan and any changes to the benefit plan design, identification of the data used and the kinds of assumptions and projections made, and the rating requirements specifically required by this State. If this State's data is not credible, describe how a larger set of data is used and how the credibility factors are applied in order to derive the rate projection.

2. The number of covered persons for the plans included in this filing. These numbers must be shown for each month of the experience period and the prior two (12-month) periods by plan and in aggregate if two or more plans are included in the rate filing.

3. Earned premiums for each month of the experience period and the prior two (12-month) periods by plan and in aggregate if two or more plans are included in the rate filing.

4. Incurred claims for clinical services provided to enrollees as referenced in Section 2718 of the Public Health Service Act for the plans included in this rate filing for each month of the experience period and the prior two (12-month) periods, and breakdown by the following categories:

   a) Inpatient Hospital,

   b) Outpatient Hospital,

   c) Physician Services,

   d) Pharmacy,

   e) Laboratory,

   f) Imaging,

   g) Emergency Room, and

   h) Others

5. A breakdown of the health insurance issuer's expenses allocated or assigned to the plans included in this rate filing for the experience period and the prior two (12-month) periods at least as detailed as the categories listed below. Provide the documentation and justification of the assignment or allocation of the expense to the plans included in this rate filing.

   a) Activities that improve health care quality as referenced in Section 2718 of the Public Health Service Act ,

b) Federal and state taxes and licensing or regulatory fees as referenced in Section 2718 of the Public Health Service Act ,

c) Total annual compensation of the ten highest paid officers or employees,

d) Total annual compensation for staff other than ten highest paid officers or employees,

e) Agents and brokers fees and commissions, and

f) Other General and Administrative Expenses.

6. A detailed calculation and documentation of the proposed rate change including but not limited to the following:

a) Earned premiums for the experience period, premiums adjusted to the current rate level, and the projected earned premiums.

b) Incurred claims for the experience period, and the projected claims.

c) Trend factors and detailed development.

d) Impacts on claims due to benefit changes.

e) Projected breakdown of the expenses as a dollar amount and as a percentage of projected earned premiums by the following categories:

- Activities that improve health care quality as referenced in Section 2718 of the Public Health Service Act ,
- Federal and state taxes and licensing or regulatory fees as referenced in Section 2718 of the Public Health Service Act ,
- Total annual compensation of the ten highest paid officers or employees,
- Total annual compensation for staff other than ten highest paid officers or employees,
- Agents and brokers fees and commissions,
- Other General and Administrative Expenses,
- Any credit from forecasted investment earnings on claim reserves or other similar liabilities, and
- A reasonable provision for projected profit, contribution to surplus, contingency charges, or risk charges. For the purposes of this section, "projected profit, contribution to surplus, contingency charges, or risk charges" means the portion

of the "projected earned premiums" not associated directly with the "claims" or "expenses."

f) Factors used to derive the projected rate change and the specific rate for any individual, employee, or employer including built-in trend factors, duration factors (such as durational loss ratio), age, geography, family size, industry, health status and other applicable rating factors.

g) Documentation and justification for the credibility factors used in the rate projection if the experience of the plans included in the rate filing is not credible.

h) Changes to the rating factors from prior rate filing to this rate filing and the impacts on the rate projection. Health insurance issuer must provide a justification for the changes to the rating factors. For example, if the age factors are modified from the prior rate filing, the issuer must show that the revenues projected before and after changing the age factors are the same.

i) Base rates and plan relativities if two or more plans are included in the rate filing. For the purposes of this section, base rate means the rate for any plan prior to the adjustment for any rating factors. The plan relativities mean the relative values of the benefit plan.

j) Description of the methodology used to adjust the base rate to obtain the premium rate for a specific individual or group, including the minimum and maximum rate change for any individuals or covered persons, the range of rate change by the distribution of members or groups. The methodology must be detailed enough to allow the reviewer to replicate the calculation of premium rates if given the necessary data.

7. Provide the documentation and calculations of the overall average rate increase and each component of rate change as described in C of the Rate Filing Disclosure Form. Efforts should be made to break down the medical utilization and price changes consistent with the data required under this section and into the following categories: inpatient hospital, outpatient hospital, physician, pharmacy, laboratory, imaging, emergency room, and other.

8. A certification by a member of the American Academy of Actuaries that rates for the plans included in this filing are reasonable in relation to the benefits provided.

9. The requirements of subsections (2) through (7) may be modified by the health insurance issuer if a reasonable explanation is provided. For example, if the rate filing involves capitation contracts that would make it difficult to breakdown the categories as required by subsection (4), the issuer may modify the categories for the purposes of reporting.

10. Since the rate filing cannot be understood without a wider understanding of the company, a link referencing a website from which the health insurance issuer's most recent Annual Statement may be accessed. The following pages or Exhibits from the most recent Annual Statement provide information that can be helpful in understanding the insurer's financial position:

    - Assets
    - Liabilities, Capital, and Surplus
    - Statement of Revenue and Expenses
    - Analysis of Operations by Line of Business
    - Underwriting and Investment Exhibit—Analysis of Expenses
    - Exhibit of Net Investment Income
    - Exhibit of Capital Gains (Losses)
    - Enrollment by Product Type for Health Business Only (Exhibit 1 of the Health Annual Statement Blank)
    - Summary of Transactions with Providers (Exhibit 7 of the Health Annual Statement Blank).
    - Notes to Financial Statements
    - General Interrogatories
    - Five-Year Historical Data
    - Exhibit of Premiums, Enrollment, and Utilization
    - Management's Discussion and Analysis
    - Accident and Health Policy Experience Exhibit
    - Supplemental Compensation Exhibit
    - Supplemental Health Care Exhibit (now being developed by E Committee)

(Note: The data included in the Annual Statement is companywide information and reported on a calendar year basis. The data submitted in the rate filing is information assigned or allocated to the plans referenced in the rate filing and may not be on a calendar year basis.)

Definition and Glossary of Terms: *Some items mentioned throughout these three sections are yet to be determined. (For example, what kind of activities can be classified as activities that improve health quality?) It is recommended that a link to the Definition and Glossary of Terms be included.*

Policy Rate Filing Record - Data Collection with Rate Review Grants

Data Element	*Mandatory Y/N*	*Definition*
State Abbreviation	Yes	The two digit State abbreviation as recognized by the US Postal Service
Reviewed by State Y/N	Yes	A yes/no flag used to identify whether the rate change was reviewed by the State. This value will be "no" for States that collect information but do not currently review rates and for States that "deem" rates approved. This will be derived data.
State Review Includes Actuary Y/N	Reviewed by State is yes, otherwise, No	A yes/no flag that demonstrates if the State review process includes a review by an actuary. Check box in SERFF
Insurance Company Name	Yes	The name of the insurance company
Insurance Product Name	Yes	The "street" name of the insurance product as sold by the insurance company
Issuer ID	Yes	The unique identifier as assigned by the HHS HIOS system.
Policy Form ID	Yes	The policy ID of the insurance product as sold by the insurance company (NAIC policy or other ID if not a NAIC user)
Rate Filing ID		The rate filing ID of the insurance product as sold by the insurance company (NAIC policy or other ID if not a NAIC user)
New Policy Y/N	Yes	A yes/no flag that demonstrates if the policy is a New issue that has never been issued before. This will be derived data.
Market Segment	Yes	Allowable values for market segment are: Large group, Small group, Individual, Conversion - Need to discuss adding small and large as an option, field will be made mandatory in SERFF
Comprehensive Medical Coverage Type	Yes	Allowable values for comprehensive medical coverage type are: HMO, PPO, POS, FFS, EPO, Other - (please note details)
Block Status	Yes	Demonstrates if the rate for the policy is "open", "closed". An open policy is one that is available for sale to new enrollees.
Rate Effective Date	Yes	Date that the rate is effective for the policyholders. Will be made mandatory in SERFF
% Change Requested	Yes	The percentage of change approved can be a positive or negative number. Demonstrated as a range of min-max.
% Change Approved	No	The percentage of change requested can be a positive or negative number. Demonstrated as a range of min-max.
Change Period	Yes	Demonstrates the time for which the premium change is effective. Allowable values are: Annual, Semi-annual, Quarterly, Other - (Please note details)
Number Affected Insured's	Yes - unless Number Affected Policy Holders is the only data collected by the State	Total number of enrolled individuals affected by the rate change. This may be null for States that only collect policy holder counts.
Number Affected Policy Holders	Yes - unless Number Affected Insured's is the only data collected by the State	Total number of policy holders affected by the rate change. This may be null for States that only collect the number of enrolled individuals.
Member Months	Yes	The member months used for the purpose of the rate development.
Annual $ for New Rate	Yes	The dollar amount of the New Annual Rate. Demonstrated as a range of min- max.
Annual $ for Prior Rate	Yes	The dollar amount of the Prior Annual Rate. Demonstrated as a range of min- max.
SERFF Tracking Number	No	The tracking number assigned by the NAIC SERFF system assigned to the rate filing?
SERFF Rate Filing Type	No	The rate filing type as used in the NAIC SERFF system. This will be pulled from the SERFF filing mode, valid values are: need to define which make sense for this collection...

Policy Rate Filing Record - Data Collection with Rate Review Grants

Data Element	*Mandatory Y/N*	*Definition*
NAIC Company ID Number	No	The company identifier assigned by the NAIC system to identify the insurer.
Description of trend factors	No	Text description of trend factors and rating factors used in developing the rate. Max 1000 characters
Benefit Adjusted Y/N	Yes	A yes/no flag used to identify if the benefits were adjusted or changed for the period.
Deductible Increase Y/N	Yes	A yes/no flag used to identify if the deductible amount was increased.
Benefit Increase Y/N	Yes	A yes/no flag used to identify if the services bevefits were increased.
Benefit Decrease Y/N	Yes	A yes/no flag used to identify if the services bevefits were decreased.
Cost Sharing Y/N	Yes	A yes/no flag used to identify if there are cost sharing requirements for the rate. Need to synch with ACA definitions.
Coinsurance Y/N	Yes	A yes/no flag used to identify if there are coinsurance requirements for the rate. Need to synch with ACA definitions.
Primary Care Copayment Amount	Yes	The copayment required at the primary care doctors office that coincides with the rate. Demonstrated as a range of min- max.
Specialist Care Copayment Amount	Yes	The copayment required at specialty care doctors office that coincides with the rate. Demonstrated as a range of min- max.
Inpatient Hospital Copayment Amount	Yes	The copayment required for inpatient hospitalization that coincides with the rate. Demonstrated as a range of min- max.
Outpatient Hospital Copayment Amount	Yes	The copayment required for outpatient hospitalization that coincides with the rate. Demonstrated as a range of min- max.
Generic Pharmacy Copayment Amount	Yes	The copayment required for generic drugs at the pharmacy that coincides with the rate. Demonstrated as a range of min- max.
Brand Pharmacy Copayment Amount	Yes	The copayment required for brand name drugs at the pharmacy that coincides with the rate. Demonstrated as a range of min- max.
Total Earned Premium Amount - Prior year	Yes	The total dollar amount collected for the purpose of premium payments.
Total Incurred Claims Amount - Prior year	Yes	The total dollar amount paid for services incurred.
Disposition of Rate Review	Yes	The disposition of the rate review, e.g. "approved," denied", "deferred",
Prospective Rate % Attributed to Claims and Capitation	Yes	The prospective percent of the rate increase attibuted to historical Claims and Capitation
Prospective Rate % Attributed to Admin	Yes	The prospective percent of the rate increase attibuted to historical Admin increase
Prospective Rate % Attributed to Broker Commissions	Yes	The prospective percent of the rate increase attibuted to historical Claims and Capitation increase
Prospective Rate % Attributed to Premium Taxes	Yes	The prospective percent of the rate increase attibuted to historical Premium tax increase
Prospective Rate % Attributed to Assessment Fees	Yes	The prospective percent of the rate increase attibuted to historical assessment fee increase
Prospective Rate % Attributed to Federal Taxes	Yes	The prospective percent of the rate increase attibuted to historical Federal tax increase
Prospective Rate % Attributed to Reserves	Yes	The prospective percent of the rate increase attibuted to historical reserves increase
Medical Price % Change	Yes	The medical price percentage of change used to develop the rate
Medical Utilization % Change	Yes	The medical utilization percentage of change used to develop the rate. Using current standards, not future MLR definition.
Medical Trend % Insufficient Prior Rate	Yes	The percentage of historical insufficient prior rate used as a factor to develop the current rate
Overall Medical Trend % Increase	Yes	Derived data - The prospective total of the Medical Price % Change, Medical Utilization % Change, and the Medical Trend % Insufficient Prior Rate